Questinonnaire / Medical history

Surname of the patient:____________________ Firstname___ ____________Date of birth._______

Surname of the insured:_____________________ Firstname _______________Date of birth.:______

Address:
City:_____________________Street:______________________________Tel.:_____________

Address of the insured (if different)____________________________Tel:______________

Occupation of the insured:________________________Employers:__________________________

Name of the health insurance____

Name of the dentist:_______________

Please answer the following questions as completely as possible before the examination. Answering the questions will also provide information of the development of jaw und dental deformities. If anything ist unclear we will help you.

1. Consist of parents or relatives jaw or tooth misaligment or braces was neccessary?

   ☐ No ☐ Yes, what kind of braces?

   ____

2. Was / is already elsewhere orthodontic consultation or treatment ?

   ☐ No ☐ Yes, when, for whom?

   ____

3. When did the first milk teeth come? __________________month

4. When did the first teeth come? ____________years

5. Where there any accidents in which the face / teeth (even in early childhood, the milk teeth) were affected?
   ☐ No ☐ Yes, which teeth, when?___________________________________

6. Was the pregnancy and the birth of the patient normal?

   ☐ Yes ☐ No, extras:_______________________________________

7. Existence of allergies, asthma, disorders, disabilities?

   ☐ No ☐ Yes, so what?____

8. Is usually full nose breathing ☐ , labored breathing trough nose ☐, mouth breathing ☐ ?

9. Already been an ear-nose-throat examination or surgery (eg tonsillectomy) performed?
☐ No ☐ Yes, when and what?_______________________________

10. There are complaints in the TMJ?
☐ No ☐ Yes

11.. Passed or are habits such as nail biting, lip biting and thump suking ?

☐ No ☐ Yes, so what? ___________________________________

12. Was / will be carried out a speech therapy?

☐ No ☐ Yes, for whom_______________________________________

13. If currently a specialist treatment?

☐ No ☐ Yes, why? Please specify doctor:______________________

14. Are you currently infectious pathologies (eg Hepatitis, HIV)?

☐ No ☐ Yes, so that:_______________________________________

15. Existence blood clotting disorder?
☐ No ☐ Yes

16. Regulary taking medication?

☐ No ☐ Yes, so that:_______________________________________

17. When and where have been carried out X-rays?

____

18. Are you in response to the orthodontic treatment necessary X-rays?
☐ agree ☐ not agree

19. Do you own an X-Pass?
☐ Yes ☐ No

17. Female patients: Are you pregnant now?
☐ No ☐ Yes What month of pregnancy?______

Important Note for female patients: Please inform us in case of pregnancy!

Nürnberg, _____________________ ___________________________________
Signature of patient/ guardian